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When individual nursing facilities have their annual Inspection of Care nursing reimbursement rate update, reimbursement for this category of service will be based on individual resident need assessments from the resident assessment instrument and will be determined on an individual facility basis. The per diem per resident amounts of staff time and staff levels associated with resident assessment scores for this new category of service item which will be used in the individual facility determination of reimbursement are for base rate .5 minutes of nurse aide time; 1.1 minutes of licensed staff time; .7 minutes of registered nurse time; and .3 minutes of social worker time and for level 1, 1.5 minutes of nurse aide time; 3.3 minutes of licensed staff time; 2.1 minutes of registered nurse time; and .9 minutes of social worker time.

01/93 (F) Social Services Effective July 1, 1990, nursing facilities will be reimbursed for social services. The reimbursement of this service item will cover the nine month period from October 1, 1990 through June 30, 1991 for the reimbursement year July 1, 1990 through June 30, 1991. Starting July 1, 1991, the reimbursement will be for a full twelve month reimbursement year.

For the reimbursement period of July 1, 1990, until the nursing facility's annual Inspection of Care nursing reimbursement rate update resulting from an annual Inspection of Care assessment occurring on or after January 1, 1991, a statewide per diem reimbursement for social services will be based on the ratio of total social services wage costs to the total nursing wage costs for the facilities in the State.

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The actual social service and nursing wage costs facilities report in the cost reports will be used in obtaining a statewide ratio, unless the nursing facility reports no social work wage costs or the facility has 120 or more beds and it reports annualized paid and accrued social service hours of less than 2080 hours. In the case of no social service wage costs reported, the facility's data will be excluded in deriving the statewide ratio. For a facility with 120 or more beds, the social service hours to be used in deriving the wage costs will be the greater of the reported paid and accrued social service hours or the annual 2080 hour standard adjusted to the length of the facility's cost report period.

For the reimbursement period July 1, 1990 through June 30, 1991, the social service to nursing cost statewide ratio derived above will be multiplied by .75 in order to prorate the nine month per diem reimbursement amount to be paid over the full twelve months of the July 1, 1990 through June 30, 1991 reimbursement year. Effective July 1, 1991, the proration will be discontinued and the reimbursement for social services shall cover the full twelve months of the reimbursement year.

The statewide ratio will be applied to the statewide average per diem per resident nursing care time amount (staff minutes multiplied by per minute wage) obtained from the resident assessments to derive the per diem per resident social service reimbursement which shall be added to the facility's new computed nursing rate.

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(G) Registered Nurse Coverage Effective July 1, 1990, nursing facilities will be reimbursed for additional registered nurse coverage costs to meet the new OBRA requirements of maintaining registered nurse coverage eight hours per day seven days a week (effective October 1, 1990). The reimbursement of these additional costs will cover a nine month period for the July 1, 1990 through June 30, 1991 reimbursement year. Starting July 1, 1991, the reimbursement will cover a full twelve month period.

For the reimbursement period of July 1, 1990 until the nursing facility's annual Inspection of Care nursing reimbursement rate update resulting from an annual Inspection of Care assessment occurring on or after January 1, 1991, a statewide per diem per resident for additional RN coverage costs will be derived based on the ratio of total additional RN coverage costs to total nursing wage costs for the facilities.

If a nursing facility reports no registered nurse salary costs in the cost report and the average hourly wages for the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) are less than the average hourly registered nurse (RN) wage for the region, the annual RN salary cost will be determined by multiplying an annual 2912 hour RN coverage standard by the average hourly RN wage for the region. The amount will be adjusted to the length of the facility's cost report period to obtain the additional salary costs for RN coverage. If either the DON or the ADON average hourly wages are equal to or above the average hourly RN wage for the region, the annualized DON and ADON hours paid and accrued at a wage equal to or above the average hourly RN wage will be deducted from the 2912 hour standard used in deriving the annual salary cost for RN coverage. If the balance of hours is equal to or less than zero, the facility's additional salary cost for RN coverage will be zero.

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If a nursing facility reports RN salary costs and the annualized paid and accrued hours are below the 2912 hour standard, the difference between the annualized paid and accrued hours and the 2912 hour standard will be determined. If either the DON or ADON average hourly wages are equal to or above the average hourly RN wage for the region, the annualized DON and ADON hours paid and accrued at a wage level equal to or above the average hourly RN wage for the region will be deducted from the hour difference. The balance of hours will be multiplied by the average hourly RN wage for the region and the product will be adjusted to the length of the facility's cost report period to obtain the facility's additional salary costs for RN coverage. If the balance of hours is equal to or less than zero, the facility's additional salary cost for RN coverage will be zero.

For the reimbursement period July 1, 1990 through June 30, 1991, the additional salary costs for RN coverage obtained above will be multiplied by .75 in order to prorate the nine month reimbursement to be paid over the full twelve months of the reimbursement year.

For the year beginning July 1, 1991, the proration will be discontinued and the reimbursement for additional RN coverage shall cover the full twelve months of the reimbursement year.

The statewide per diem reimbursement for additional RN coverage costs will be based on the ratio of the total additional RN coverage salary costs obtained from (C) above to the statewide total nursing wage costs for the facilities.

The resulting statewide ratio will be applied to the statewide average per diem per resident nursing care time cost amount (staff minutes multiplied by per minute wages) obtained from the resident assessments for the facilities to derive the statewide per diem per resident RN coverage reimbursement which shall be added to the facility's new computed nursing rate.

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The final additional salary costs for RN coverage obtained above shall be added to the facility's DON costs as reported in the cost report. The adjusted facility costs shall be used in determining the regional DON reimbursement ratio used to derive the DON reimbursement amount.

==04/98

For facilities which have obtained a waiver of this RN coverage provision from the ~~Illinois Department of Public Health~~ DPH and for facilities which do not meet the conditions described above, the additional salary costs for RN coverage will be zero. For fiscal year beginning July 1, 1992, no additional salary costs will be added for RN coverage.

ii. Determination of Nursing Rates

(A) The rate each facility receives will be determined by the assessed needs of residents the facility serves. Annually, IDPA nurses will conduct an assessment of a 100% sample of the Medicaid residents by level of care in each home. The needs of the residents in the sample will be assessed with the Resident Assessment Instrument. An amount for each resident will be calculated by multiplying the number of minutes from the assessment by the appropriate wage/wages for each assessment item, adding the appropriate amount for fixed time and amounts for vacation, sick and holiday time, supplies, consultants, and the Director of Nursing. The average of the rates for residents in the sample will become the facility's per diem reimbursement rate for each Medicaid patient in the facility for the next twelve months, at which time a new rate based on the most recent facility profile will be effective.

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(B) For the reimbursement period July 1, 1990 through June 30, 1991, the per diem reimbursement amounts for comprehensive patient assessment shall be calculated by multiplying the number of reimbursement staff minutes for this category of service item by the statewide average per minute staff wages and further multiplying this amount by .75 in order to prorate the nine month per diem amount to be paid over the full twelve months of the July 1, 1990 through June 30, 1991 reimbursement year.

For the reimbursement period of July 1, 1990 until the nursing facility's first annual Inspection of Care nursing reimbursement rate update resulting from an annual Inspection of Care assessment occurring on or after January 1, 1991, the prorated per diem per resident amount for comprehensive patient assessment shall be added to the facility's new computed nursing rate.

When individual facilities have their annual Inspection of Care nursing reimbursement rate update, the prorated per diem amount for comprehensive patient assessment calculated for each resident will be added to the other amounts calculated for the assessed needs of the resident and the facility rate will then be determined.

(C) The prorated per diem amount for comprehensive patient assessment calculated for each resident will be added to the other amounts calculated for the assessed needs of the resident and the facility rate will then be determined.

(D) Effective July 1, 1991, the proration of a nine month reimbursement to be reimbursed over a twelve month period will be discontinued and the reimbursement amounts for comprehensive patient assessment shall cover the full twelve months of the reimbursement year.

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A copy of the Resident Assessment will be left with the facility at the completion of each Inspection of Care.

10/92 (E) When individual nursing facilities have their annual Inspection of Care nursing reimbursement rate update through June 30, 1991, the per diem reimbursement amounts for social services, continence restorative, specialized medication monitoring, restraint management and reduction, and communication shall be calculated for each resident by multiplying the number of reimbursable staff minutes for these category of service items by the appropriate staff wages and further multiplying these amounts by .75 in order to prorate the nine month per diem amounts to be paid over a twelve month period.

The prorated per diem amounts for these new variable time category of service items calculated for each resident will be added to the other per diem amounts calculated for the assessed needs of the resident and the facility rate will then be determined.

Effective July 1, 1991, the proration of a nine month reimbursement to be reimbursed over a twelve month period will be discontinued and the reimbursement amounts for these new variable time category of service items shall cover the full twelve months of the reimbursement year.

==04/98 (F) For residential nursing services provided to Medicaid residents in ~~skilled and intermediate care~~ nursing facilities from January 1, 1989 and thereafter, ~~the Department~~ DPA will determine nursing rates according to the following ~~four~~ steps:

==04/98 (1) Calculation of preliminary nursing rate: For each facility, a preliminary nursing rate will be computed according to the methods specified in ~~3(a)(i)(A) (II)~~ subsection III.C.4.a.i.(A) through (G).

TN # 98-3 APPROVAL DATE SEP 16 1998 EFFECTIVE DATE _____

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(2) Calculation of the final nursing rate: For each facility, a final nursing rate will be equal to the sum of the nursing rate plus an add-on for Care Planning equal to $.45 per resident day statewide. Effective July 1, 1992 and ending August 31, 1993, there will be an additional wage adjuster add-on of $1.58 for geographic area that have wages equal to or above the statewide average and $2.00 for geographic area that have wages below the statewide average. Effective September 1, 1993, the wage adjuster add-on will be eliminated.

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(G) Notwithstanding the provisions set forth for reimbursement of long term care services, effective January 18, 1994, reimbursement rates for nursing facilities will remain at the levels in effect on January 18, 1994, with the following exception:

(1) The results of Inspection of Care surveys for which the exit conference is completed prior to January 18, 1994, will be processed and reflected in facility rates effective with the annual nursing rate adjustment date.

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(2) Effective for services provided on or after July 1, 1996, facilities which are located in an area which has changed geographic designation due to unique labor force factors shall have rates recalculated based upon the ceilings and norms of the newly designated geographic area.

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01/94 iii. Interims

(A) A facility may request an interim IOC if the following criteria has been met: a 25 percent or greater turnover in Medicaid residents since the last IOC or a sufficient reason to believe that there has been a seven percent or greater increase in the average per patient care time. Upon reassessment, an amended 2700 will be forwarded to DPA. Upon receipt of the amended 2700, the facility's rate will become effective for the final six months of that facility's rate year.

01/94 (B) For nursing facility reimbursement rates that are maintained at levels in effect on January 18, 1994, the following provisions shall be complied with when requesting an interim IOC:

(1) Rates may change based upon an interim IOC conducted at the facility's written request for any facility which changed ownership no earlier than 90 days prior to and not later than January 18, 1994. The interim IOC request must include justification and documentation which supports one of the criteria found in (A) above.

(2) Interim IOCs may be conducted, at the facility's written request, if there has been a change in the Medicaid census since the last IOC survey in accordance with subsection (A) above, except that the requirement that the request must be made within 180 days of the last IOC need not be met. The written request must contain documentation supporting the change in Medicaid census.

==04/98 (3) ~~The Department~~ DPA reserves the right to initiate interim IOC surveys, if necessary, based upon a significant reduction in the level of resident care or for the health and safety concerns of residents.

(4) Any rate adjustments that result from an interim IOC conducted under these provisions will have an effective date of the first day of the month following the exit date of the interim IOC.

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(5) Requests for interim IOC received through January 18, 1994, will be processed in accordance with (A) above.

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01/94 iv. Reconsiderations

(A) A facility may request a reconsideration of the resident assessment conducted by the IOC team if the facility believes the assessment does not accurately reflect the level of need of its residents. The facility will be given the IOC assessments in batches of 20% as the Case Manager completes them for the purpose of allowing the facility time to review the assessment prior to exit conference. Differences between the facility and the IOC team regarding level of need of the residents are to be addressed using a three-step approach:

(1) Exit conference negotiation between the facility and IOC team;
(2) Central office arbitration; and
(3) First level review.

10/92 (B) At the exit conference, the facility must state the functional and service needs that it wishes to dispute. The facility is responsible for providing supporting data to the IOC team in an effort to reconcile the differences. When the differences are not reconciled through negotiation, the IOC team nurse will provide the facility appeal/ arbitration request forms on which the facility must record the level of service it believes accurately reflects the residents' needs. The nurse will automatically forward the appeal/arbitration request forms and supportive documentation provided by the facility to the central office for arbitration.

(C) Arbitration is contingent upon exit conference negotiation and the submittal of the completed appeal arbitration request forms to the IOC team.

(D) First level review is contingent upon the previous steps having been completed.

(E) Final resolution of the reconsideration process shall be within 100 days of the date of the exit conference which constitutes the first step of the process.